

# Information Exchange Workgroup

## Draft Transcript

April 8, 2011

### Presentation

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good morning, everybody and welcome to the Policy Committee's Information Exchange Workgroup. As a Federal Advisory Workgroup, there will be opportunity at the end of the call for the public to make comment. Let me do a quick roll call. Micky Tripathi?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

David Lansky could not make it today. Peter DeVault?

**Peter DeVault – Epic Systems – Project Manager**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Connie Delaney? Gayle Harrell? Deven couldn't make it either. Latanya Sweeney? Charles Kennedy? Paul Egerman? Jim Golden? Dave Goetz? Jonah Frohlich? Steve Stack could not make it. George Hripcsak? Seth Foldy? Jim Buehler? Walter Suarez?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I'm here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

David Ross? Hunt Blair? George Oestreich? Kory Mertz?

**Kory Mertz – NCSL – Policy Associate**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Josh Seidman?

**Josh Seidman – ONC**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Art Davidson?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Sid Thornton?

**Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay, I'll turn it over to Micky.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Thanks, Judy. Thanks, everyone who was able to join the Information Exchange Workgroup. Because we scheduled these two meetings after our last call, realizing that we were going to need a couple more calls, it sounds like we've had a lot of attrition in terms of people being able to attend. So perhaps one thing we want to think about—and maybe we can come back to this after—is going through the agenda, and certainly want to be able to respect those who were able to make the call so that we can have the discussion, get our input. Then try to turn that around into something that we can send around to everyone so that we can get the input of the broader workgroup as well.

The agenda today is basically to continue the review of the draft comment letter to the Meaningful Use Workgroup. You may recall that we had broken this out into two pieces. We took the recommendations that were made by the Meaningful Use Workgroup for public comment and divided those up into those that were continuations of stage one requirements and we got our way through those and wrote a letter and submitted that to the Meaningful Use Workgroup. Then we decided to break out into a second letter those pieces that we weren't able to get to before the April 5<sup>th</sup> meeting. Which were largely new requirements that did not have a connection back to a stage one requirement and a couple of the public health requirements that we think needed a little bit more discussion in the workgroup.

What we want to do on slide three now, if we can please forward to that, what we want to do today is actually instead of trying to approve the revised ILPD recommendations—let me back up for a second. There's also in parallel, you may recall we had been working on the provider directory recommendations, at the last Policy Committee meeting Walter Suarez was able to attend in person, for which we're very grateful, and walk the Policy Committee through the ILPD recommendations. The Policy Committee came back with a suggestion that we try to streamline and categorize the recommendations in perhaps a shorter, crisper way, and also that we try to streamline the use case representation as well. Jonah and I will be presenting these to the Policy Committee next week, assuming that the government is still open, on the 13<sup>th</sup>, and so we're working on streamlining that deck.

Rather than going through that on this call, what we would propose is that we distribute that to all of you off line later today and ask for your feedback by early next week, say end of day Monday. We'll put that in an e-mail, and then we'll be in a position to be able to give it to the Policy Committee. Since it's just really streamlining recommendations and we've already approved it at the workgroup level, I would prefer not to have us go through that on this call so that we can continue on the meaningful use agenda. So if everyone is okay with that, we'll proceed with that plan.

That puts us in a position then to dive into the meaningful use recommendations. I think we still want to divide those into two. One is a set of, I think today what we have on the agenda are the new requirements, by new meaning that they don't have a hook or any legacy requirements in stage one. They are recommendations that came out of the Meaningful Use Workgroup that genuinely begin in stage two or stage three. Then we have a second set of issues related to public health that I think we're going to address on the next call, which is on April 15<sup>th</sup>. Those are related to the reportable labs, I think is the one remaining issue there that we want to give greater thought to and have a little bit more time to discuss. First off, let me make sure that I got that delineation right. Kory, did I get that right?

**Kory Mertz – NCSL – Policy Associate**

Pretty much. I think there's one maybe hospital discharge that's in there, but all the other ones are the brand new ones, so yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay. In terms of what's here today, you mean?

**Kory Mertz – NCSL – Policy Associate**

Yes. You definitely provided the other piece, yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay. First off, let me pause and see if that's what everyone remembers and make sure that everyone's okay with that general plan. I will take silence as affirmation.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Micky, I think that's right. The one item, I don't know if you mentioned it and I missed it, is the recommendation on the HIE metric or the HIE requirement. I know we made some recommendations already around that, but there were some things that were pending.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. Thank you, Walter, for raising that. I think we'll do that on the next call as well. I would say that we'd take that one as well as the reportable labs on the next call, and if we can focus on those two that will give us enough time to really have a deep discussion, I think, of those two. We got an e-mail from Deven; she was unfortunately not able to make the call today but gave a synopsis of the discussions that happened on April 5<sup>th</sup> at the Meaningful Use Workgroup. There may be some other perspectives, if we want to think about, for diving into that conversation.

We'll try to get as much information as we can out of the Meaningful Use Workgroup hearings from that day. I know Josh is on the call and maybe you have something to add now, Josh. I know that they apparently had a discussion about whether it even makes sense to think about that and the way it was being thought about in stage one. Maybe we ought to take a fresh look at how we want to think about information exchange going forward and provide some perspectives on if we want to move to genuinely creating the foundation for query response. For example, what are the ways that we would recommend that we start to approach that in the way of meaningful use requirements, rather than going backward and picking about language that everyone agrees was unclear and not particularly great going forward, but that no one wants to revisit. Josh, is that a fair sense of what the discussion was on April 5<sup>th</sup> on that point?

**Josh Seidman – ONC**

Yes. I think that there were good discussions but there were still a lot of questions and I think we'd encourage some final feedback from the IE Workgroup before trying to come to any conclusion. But those discussions can continue through April just as long as there are some final recommendations to be discussed by the Policy Committee at the May 11<sup>th</sup> meeting.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

This is Walter. I attended that meaningful use ... meeting earlier this week. I think there was, as Josh points out, there was a lot of good discussion specifically about this whole question of the information exchange requirement, and Deven did a great job really reflecting our discussion from this group. I was very impressed with how much she was able to remember from that discussion, I don't know that she had notes in front of her, but, yes, there was quite a bit of discussion about that. Judy Murphy, who is a member of the workgroup, led basically that section, so we might want to exchange some e-mails with Judy to make sure that her questions that she will be probably presenting at the next meaningful use meeting will be addressed on the information exchange part.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay, I think that's great. Maybe we can off line work on that and build an agenda toward, as Josh says, toward a May 11<sup>th</sup> HIT Policy Committee meeting and figure out how to coordinate that with the Meaningful Use Workgroup. I think the issue in general is a huge issue obviously and I think is one that the IE Workgroup members would be very interested in weighing in on that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

What the Meaningful Use Workgroup is going to rely, according to their discussion basically, is going to rely on this workgroup, our workgroup here, so that's why this is an important point.

### **Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay, great. I think that what we want to do is go through and at least finish the housekeeping on the recommendations that were made just so we're on record with comments back on all of the recommendations that were made for the first round. Then in the next round, we can start to look at what came out on April 5<sup>th</sup> and really set the agenda for the perspective that we want to bring to the table and provide to the Meaningful Use Workgroup going forward.

If we can move to the next slide then we can really dive into the agenda here, which is continuing marching our way through these recommendations, which I know feels like a bit of a forced march. But some nature of this detail level work is always, it's a little bit like a slog but I think it's important to go through each one and then we're able to step back and provide some good perspective, although the details always feel like they're difficult to go through. So I'd appreciate everyone's patience and engagement on this. Next slide, please.

Just marching our way through, this is, and I got some specific comments back from Steve Stack, who is out of the country and not able to join the call, but he did provide some slide-by-slide comments. As we go through these I will try to make sure to bring his comments into the conversation as well. This, we're on the public health button recommendation, which as you can see, this is a proposed stage three recommendation for hospital and eligible professionals. The idea is that for a set of mandatory tests there would be a reportable public health submission button, presumably in EHRs, that would allow bidirectional messaging to public health for whatever it is that ends up becoming required to report to public health. And importantly to be able to accept and consume information from public health, like follow up case management requests, public health alerts, what have you.

As we tried to find a little bit of perspective on this, certainly some of the specific questions are what kind of interfaces are needed for this in terms of the contents. We might need to have condition specific clinical data and we would need standard mechanisms for extracting from the EHR. Those are just a couple of the things that would get raised by this.

Let me pause, just looking at Steve's e-mail, he didn't have anything specific on this particular slide except to say that public health is an area that we've been spending a lot of time on. But let me open it up and see if people have any general comments on this one.

### **Art Davidson – Public Health Informatics at Denver Public Health – Director**

Micky, I just wanted to clarify that it does not necessarily require a test that there would be a reportable event to a local or state jurisdiction. For instance, after a vaccination Guillain-Barre does not have a test that helps identify that syndrome, but it is a reportable event. The same for aseptic meningitis, it would not have necessarily a lab test that would help you identify that this is a case that should be reported. Electronic lab reporting takes care of all of those lab tests, so this is something that would fit into that category when there is a reportable condition, which doesn't necessarily have an associated abnormal test.

### **Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay.

### **Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Just a couple of comments on that too. Well, there are a number of points to be clarified perhaps. I think overall this theory of the green button or whatever you call it, is good. I think the idea of creating a mechanism to report these events or conditions or findings very quickly and interactively, bidirectionally, as is pointed out, is good. I think there's a combination of elements that have to be cleared up because this combines probably a number of things.

One is the syndromic surveillance reporting, which reports basically on almost real time findings of clinicians at emergency room departments and other settings. At the same time, it combines also

reportable conditions, notifiable conditions, and then also mixes up the whole questions and concepts around lab reporting and conditions that require a lab test to be reported.

It's not very clear in my mind, and in the minds of a number of people, the scope of this particular metric and this particular functionality. And there might be some—I know there are some concerns expressed by a number of people, particularly coming from the epidemiology side, about the possibility of creating more confusion about what gets reported. What gets, as a confirmed reportable event, confirmed through labs or some other mechanism, versus a clinical finding, a fever or some other clinical finding in the course of a consult. I think it is going to be very important to make sure that this gets clarified and distinguished and scoped out from these other mechanisms of reporting that we have and that is being done for public health purposes, the syndromic surveillance reporting, the lab reporting, and the notifiable condition reporting.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

I totally agree, Walter. I think that this is something that may not be ready fully for primetime yet. I had this discussion with Seth a little while ago, in the late July meeting that we had around public health. It was just around the same time that the blue button was announced in the press, I think from Marco and others in the VA, and it just seemed like all of a sudden no one in the testimony had said we want a public health button. But the conversation at the hearing resulted in this discussion about hey, how about a public health button.

**Seth Foldy – Wisconsin – State Health Officer**

I wasn't there for the login so I apologize for just announcing myself now. There's obviously a lot of confusion about what was intended by the button concept. One issue about the concept of a button is that it implies that a human has to push the button and what is of course most valuable we think to both clinicians and to public health, is that certain types of reporting be automated, not dependent on somebody pushing a button. On the other hand, what this reflects are some very important needs. If I were to prioritize the highest need, the highest need is that there should be a system whereby EHRs report to public health non-laboratory information that reflects mandated case reports that public health has to receive. What I'm suggesting is you might want to separate the concept of a button from the concept that the EHR will assist the clinician by preparing a certain set of reportable case reports and sending them to public health.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Seth, is that syndromic surveillance?

**Seth Foldy – Wisconsin – State Health Officer**

Actually, no, that is a second issue here. Syndromic surveillance most often is seen as just the continuous feed of certain event data. One could push a button to send that data every day. But what I'm imagining here would be forms that were specifically constrained to certain events that would be reported on a routine basis, you could use this for syndromic surveillance. But I think the highest priority would be on information that has been well established over time. Public health needs to know about a case of hepatitis, a case of gonorrhea, that could be obtained from the electronic health record and sent to public health, sometimes as a supplement electronic laboratory report, and sometimes as the only report that goes to public health.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

I think the thing about this one that confuses me is it seems like it's blending two things. One is a particular function, a technology function, and the other is about some genuinely new content, which you were just talking about, Seth. I guess I don't understand why we would have any particular way of instantiating the function being a meaningful use requirement. What we want to do is establish that there's certain content that we think is important and that the physicians ought to document in a way that facilitates that content being generated and reported, but that if Epic wants to create a button, great. If they want to figure out how to automate it, that's great. But that ought to be left to how the vendors want to do it according to a set of standards, if the Standards Committee decides that there's a set of standards that could go along with that.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I'm wondering, I hate to stand on process, but I'm wondering if there's enough consensus here that this is a really interesting idea but not really ready to be a meaningful use requirement. I think it tees up a whole body of issues we've discussed, where there's some really good ideas that might need more discussion and development and thinking, I'm thinking of the shared care plan kind of concepts and things like that. But I wonder if just in the interest of time, if people agree with that, maybe we move on to the next thing and just say we don't think this one's ready yet.

**Seth Foldy – Wisconsin – State Health Officer**

Yes, this incorporates also the whole concept of receiving alerts from public health, making it an even more complex recommendation or objective. But what I do think we should be able to achieve in time for stage three that would be of high value to both the providers and hospitals and to public health, is the automation of sending certain non-laboratory reportable event data from the clinical EHR to public health to automate one additional piece of that stream besides electronic laboratory reporting. I do think that if we could keep that in our sights for stage three, we will have created a realistic and also meaningful goal.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

This is Walter. I think the meaning of automating is the question I have, Seth, because I think there is the need to establish electronic standards for submitting a clinical report of a condition that appears to be notifiable or that is a notifiable condition from the clinic to a public health agency. So the electronic submission of a clinical summary or a clinical report, and when I say that I mean the clinical data that public health requests on a notifiable condition, the electronic standard for that is one aspect. It establishes what is the templated CDA version, if you will, of a public health report on a notifiable condition. That is one aspect that needs to be done and established and then requires that EHRs have the capability of producing those types of public health messages.

The other aspect is the workflow of creating and sending that, and that's where this button becomes a question about whether really, like I said at the beginning, ideally here one person at the clinic could just press a button that says "public health notifiable condition report" and then send that out electronically. But the reality behind the scenes there is the creation of the message in a standard format, HL7, CDA type template or things like that. So I think it's two separate parts, and maybe Seth that's what you were trying to point out, it really is two separate things. It's standards for the message and then the workflow process, the automation process of actually submitting that to public health.

**Seth Foldy – Wisconsin – State Health Officer**

Right. I agree with everything you said.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Can I suggest as a process point then that we agree that this, as written, is not ready for primetime and next call we can—because we're going to be talking about reportable conditions on that next call. Maybe we can take up Seth's point about whether we want to send a statement about what we believe is the importance of automation of certain types of reporting in general that would just be a context setting placeholder for the Meaningful Use Workgroup.

**Peter DeVault – Epic Systems – Project Manager**

I'm fine with that.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Art?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I think that's reasonable, Micky. I think it's helpful to tease these things apart. They got conflated somehow and it's important for us to, as Seth is pointing out, to move forward in allowing EHRs, not laboratories, EHRs to do what we expect to be done from a public health point of view based on notifiable diseases and conditions that occur around the country that do not have a lab test associated with it.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. I think on the next call we can take up how we want to convey generally that to the Meaningful Use Workgroup, to Seth's point, so it doesn't get lost as we start to think about stage two and stage three.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

That would be very helpful, I think. There are three different questions. Does this mean syndromic surveillance? And I think we've decided certainly not primarily. Are we talking about reportable conditions? I think we've decided that that is something worth pursuing. Then the third question is, should public health be able to send an alert to an EHR and what does that mean? That's a third issue that we haven't answered. What I will say is there's an instantiation being stood up that uses the Info button standard that would allow a clinician to be notified that an alert might be relevant to a patient they're seeing in the context of care and pull down that alert. It was never called the Public Health button. It does exist, and we might want to also keep a placeholder as to whether or not in stage three some standard for being able to consume a public health alert might be a reasonable objective. However, I don't think it should be conflated with sending the reportable condition data to public health ideally.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

One other just parenthetical note, there is another standard called the Info button which is the standard for people to access patient education materials. So as we go forward we'll have to come up with a term that clarifies that.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

We're actually leveraging the Info button standard.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Interesting.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Again, I'm strongly in favor of keeping these as separate rows, not conflating them in a single row, and look forward to a discussion at the next meeting.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay. Okay, great. Can we turn to the next slide, please? This one is, as the title suggests, EHR is going to exchange data with PHRs, incorporate patient generated data. So these, again, are stage three recommendations for requirements. The first thing: EHRs have the capability to exchange data with PHRs using standards based health data exchange, and then offer the capability to upload and incorporate patient generated data, example, electronically collected patient survey data, biometric home monitoring, etc., into EHRs in clinician workflow.

Before we begin our discussion let me just ... comment, which was—let me make sure that it's ready for public consumption, yes, that's fine. His comment on the slide was I think as long as standards require EMRs to be able to send and consume germane information, then not much more need be done in stage two to facilitate the stage three goal. So with that as context, what are people's thoughts on this one?

**Peter DeVault – Epic Systems – Project Manager**

I think it's fine as a stage three goal. I'm not sure what else we're supposed to say about it at this point.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Yes, unless we strongly disagree with it. This also is one that feels a little bit like it's more a technology or certification requirement type of thing rather than a meaningful use requirement, which is I think more behavioral than clinically.

**Peter DeVault – Epic Systems – Project Manager**

Right, and I would like to see the Standards Committee be specific about what kind of standards will be used to do this. It's pretty broad and vague the way it's stated now.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. I know there was a thought among the Meaningful Use Workgroup earlier that we want to move to, in the meaningful use recommendations, move to more clinically focused types of requirements and then have the Standards Committee weigh in on how that gets instantiated in technology requirements. I don't know if there's anything we want to say about that in general or if there have been conversations among the Meaningful Use Workgroup about this among other requirements that feel like they're very much about just saying the technology has to do this. Rather than clinicians ought to behave in this way and the technology ought to be, and then have the certification process decide how much we want to impose on technology vendors in the way of requirements to facilitate the behavioral recommendations that are there.

Unless anyone has any strong views on this I guess we could either leave it as is or we could make a note that this seems like a technology requirement. As is, I guess it's fine for stage three, but we may want to move to something that's more clinically focused rather than specifying a technology requirement in the meaningful use requirements. Does that sound like it makes sense as a general comment?

**M**

Micky, are you saying that we should re-word this, or go back to them to say give us a specific behavioral context in which to speak about this?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Yes, I guess I wasn't that specific even. I'm getting the general sense, just by the comments we've just had, that people are okay with the general concept and I think that there certainly is a general recognition that we need to be thinking about PHRs and how PHRs become a part of this picture. At least my sense of the pulse here is that that's generally right. I'm just suggesting that we either want to get specific about it, or given that it's stage three and a little bit further out there, maybe just offer the general recommendation that in the context of this as well as others you may want to be focusing more on a clinical type of approach rather than—

**M**

One of the things that came up in the meeting the other day was talking about ways for patients to actually make corrections in their records. And maybe rather than trying to do everything that's listed in proposed stage three, is to say is there a stepping stone for patients to make a change, or how would that be dealt with in stage two? Because there's going to be so much information, or there should be so much information flowing to patients around their records that they would see something that's incorrect, might that be something we try to promote as a stage two effort? I'm not asking to change anything here. If you want to just move on, that's okay. I'm reading the last comment. Is there something in stage two that we can do?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Yes.

**M**

I'm stretching to find something.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

I'm just wondering whether this is, I think it's been suggested here as a new requirement, but in a way doesn't it seem like it's a continuation of the requirement for providing patients with summary information in whatever means they ask for or something? I forget the exact language of the stage one, but there is something like that in there, right?

**M**

This is really saying that it's linking to a PHR and the EHR can consume PHR data.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right.

**M**

That's a bit beyond just giving people summaries.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. I guess what I was suggesting, though, is it feels like it's on that trajectory that's saying your first responsible for providing the information to them, and then I think, at least on the hospital side, I think stage one says in the digital means of their choice, the electronic means of their choice. I know there's a lot of confusion about what exactly that term means, but that's already in there. So now we're even, by stage three, trying to further specify it to say, to the extent that there are patient facing applications or patient controlled applications out there, you ought to be offering the capability to both deliver and consume information with patients if the patients want it.

**W**

I wonder, it feels to me like there are three layers here. One layer is just the transport of information, and it feels like the things we're already using for transport, whether direct or whatever, would be the same ones that you would either send or receive from a PHR with. It feels like a second layer which was more into standards is what kinds of content would patients want to share that might be different from what we've already specified. Because things like activities of daily living or symptoms, so there might be a set of things around the types of data and our ability to express that in a structured form.

Then last, I think there are a lot of questions around how you authenticate a patient, but that feels like it's more PHR than EHR facing. I guess you have to, at some point, say yes, I'm going to receive information from this patient from this PHR, so there's going to be some validation process in the EHR for doing that. It feels like the first issue transport resolved. The second around content is definitely a rich area. The third is complex and I'm not sure how we tackle it.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I think it's a good summary of at least the three areas. I think the second area, the content, going to the point that, Micky, you were making about this being a new extension of the current requirement to provide consumers with their health information in various modes, I think that standardization should not be driven by the recipient in terms of a personal health record being the recipient in this case. I think the standardization of the content is something that a consumer wants a summary of their current medical records, or maybe it's the current events in their medical record, and the standard should be set to fulfill that, which standard organizations are already moving in that direction, defining the templates for the summary messages.

Whether the delivery is to print out a fax, a USB, a CD, or a message going to an e-mail or a message going to a personal health record, those are different, not only mechanisms to deliver it, but also recipients. I would try to isolate or separate the content discussion from the fact that this has been asked to be delivered to a personal health record. I think what this is asking is to establish some standard capability for EHRs to send a defined content message to a personal health record, and the content message is something that is defined by the type of summary that is being produced, but it's not defined by the fact that it's going to a personal health record.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right, but if we're going to change this, to Art's point and to your point, Walter, this is really just bidirectional and it's just each line is just specifying a different direction. One is that information ought to go out of the EHR in a standards way that a patient can use. The second is that meaningful information ought to be able to incorporate it in EHR. So do we want to try to rephrase these to basically say that, rather than focusing on particular technologies, like a PHR? This is stage three, who knows what we're going to call whatever those patient controlled applications are then. Do we want to say something about

that providers ought to be providing information to patients in a meaningful way. Similarly, on the upload, the inbound to the EHR something similar except I would suggest that we put in the caveat that it be something that both the clinician and the patient agree is meaningful. Because I don't think we want to have a circumstance where patients are just uploading all sorts of stuff that physicians find totally meaningless and therefore don't use.

So what I'm suggesting is, do we want to turn these into behavioral ....

(Audio interruption)

... ought to be able to upload information with ... to put in the caveats there that are appropriate. I don't know how different that would be than what the stage one requirements are now. I'll have to look at the details.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

My sense is this is defining a requirement about a specific recipient, which in this case is a personal health record. But it's not, in my mind, defining that because according to a personal health record the message content should be different than the one that is already standardized for providing consumers with their health information. Otherwise, we would be customizing messages for personal health records for putting something on a USB for sending it to another EHR, and that doesn't seem to make sense.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I completely agree with that for the first row. But for the second row what we're talking about, incorporating patient generated data into the EHR, I think there will likely be new categories of information, there should be anyway, that aren't typical clinical categories you probably want to maintain, whether it's metadata around provenance, or whether it's different categories like patient satisfaction. And the recommendation is that we give more thought to the categories of data that would need to then be subject to some kind of standardization. But I don't know that that's true for that second row.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

The second row seems to be not as specific to personal health records, as to person-generated data. A person could enter data into his or her electronic health record and that's person generated data. Or he could upload a copy of some information they typed into the electronic health record, or they can ask a PHR or pull out from the PHR data to transfer to an EHR. So the second row is not exclusive to personal health records, in my view.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. But do we want to turn that into, this is Micky again, turn that into something that says that physicians ought to do that. Rather than saying that they should have a technology that has the capability to do it, the meaningful use behavioral part would be to say that physicians ought to do this thing, which is upload patient generated data. We may or may not get to say what type of data we are thinking about, but that is more the behavioral part of it, and then the Standards Committee can think about what standards are needed for that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, I like that. I think that's less constrained to a specific type of technology usage, like PHRs.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. Okay, well if people are okay with that general framing maybe we can play with some language and then try to share it. It sounds like we're all in agreement that the goals that are trying to be accomplished here are the right goals. It's just a question of what's new and how do we characterize this as more of something that is a policy orientation related to what types of things we want physicians to be doing, rather than technology in a standards type of orientation which says that you ought to have tools that have that capability.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, I agree.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay. Well, let's move to the next one then. This one is a proposed stage two requirement, listed as a new one, where the stage two would be a list of care team members, including PCPs, available for 10% of patients in EHR and then increases in stage three to 50% of patients via electronic exchange. I'm not sure exactly what that means, but perhaps we can discuss that. Then in some of the comments we have here issues to consider potential to use information to achieve this objective directly or enabled by core services, for example, EMPI or claims data, and then what would be the policies and issues in exposing this information to providers.

Before we begin, let me just make sure that I'm incorporating Steve Stack's comments. His comment on this one was, "I wish I could hear why this is part of meaningful use. I don't see how this rises to a level of a separate metric in the MU program, and I don't see what value is added to tracking every last person in the care team for the MU program. I'd recommend dropping this one altogether."

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I can just hear what would come from Christine Bechtel if we were to say that back to the Policy Committee. I don't think that that's going to be—

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

She'd be wildly supportive.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

She's wildly supportive of having this care team member be identified. This is part of care coordination.

**Peter DeVault – Epic Systems – Project Manager**

There's at least some difficulties in how it's written. Patients in the EHR might include all kinds of patients who aren't current, or even alive. At the very least we'd have to carefully constrain what we mean by patients in EHR.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right. Actually, we could make it something more current in its statement, rather than just in the EHR it could be active patients in the last year, or something like that.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

We also would have to define care team members, right?

**James Golden – Minnesota Dept. of Health – Director of Health Policy Division**

Exactly. This is Jim.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

It's interesting, I love the concepts, but I think this is among a class of measures that are trying to create care processes that aren't yet there. Then it's challenging to figure out what the meaningful use requirement and then the technology piece of it would be, because obviously you want doctors to know who the other care team members are, but I don't know that we've protocolized how you do that.

**Peter DeVault – Epic Systems – Project Manager**

Agreed. I think that's right on, Claudia. A lot of patients might not even have a PCP or a well-defined care team.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

I also wonder, when we think about all of the other care processes that we're working on for meaningful use, so for example, the care transitions and summary of care exchange, in order to do that you're going to have to list who the specialists are. For example, if you're doing that electronically, because you're going to need to be able to have that proper addressing and all of that. I almost wonder whether if a

clinician is genuinely doing all of those other things, this would just come along, this would be the foundation that ends up getting created by conducting all of those other processes.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

That's a really interesting point. I always like the elegance of that kind of approach because it doesn't create extra steps that are simply steps along the way.

**M**

Let me try to understand here, Micky, you're saying that this is a byproduct of other meaningful use activities?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Yes, it's a collection of other meaningful use activities that this would really come out of that, almost in the same way that, as we were thinking about the provider directory conversation, and I forget whose comment it was in the hearing, was that directory information is the byproduct of a business process. You don't want to be telling people that they need to create a directory for the purpose of creating a directory. In the same way, I'm suggesting that if we looked at all of the other business and clinical processes that, taken together, constitute meaningful use, that the byproduct of that would be the creation of the care team members because you would have to do that in order to fulfill those other requirements.

**M**

So again, back to your way of expressing this more in a behavioral sense, is Steve Stack's approach saying there is no behavioral method to describe this, we should just get rid of it? Or is there some sort of behavioral wording we can use here?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

My personal thought would be that we could get rid of it because it's going to be taken care of ....

**Peter DeVault – Epic Systems – Project Manager**

I agree with that approach and I think if we explain that in a letter, not that we disagree with the intent of this, but think that it should be accomplished through normal care delivery processes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I agree with that as well. I think we should be clear in our comment that we're not disagreeing with the spirit of it or the intent of this, but it's something that occurs in the normal process of care delivery. And trying to force it into some electronic health record application is unrealistic.

**Seth Foldy – Wisconsin – State Health Officer**

I would be a little cautious, the language that I've just heard seems to contradict the statements made earlier that we're trying to set up a process that may not fully exist today by requiring it to be automated. I sense a contradiction. I think we should perhaps endorse the concept but express our reservations that the technology requirements are the way to implement it.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, that's exactly what I was trying to say, Seth.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

And also point out that we think that a large portion, if not all of it, might actually be accomplished as a byproduct of the other processes that were required, and the strong sense of the workgroup that Art Davidson should break this to Christine.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

She's not the only one. There will be others as well.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Well, so what do you think, Art, if we did that, say that a specific requirement, we don't think that this ought to be a standalone requirement. We certainly agree with what's trying to be accomplished here, but believe it ought to really be a part of clinical processes and we feel pretty confident that a lot of it will be accomplished even by clinical processes that are identified today, let alone what's going to be accomplished in a new ACO world.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I think we can try that approach. We'll see how the Meaningful Use Workgroup looks at it. I don't think it's unreasonable. I think we do need to endorse the concept and then say we think it's going to happen. They may come back to us and say, well, we don't see exactly how it's going to happen and we'll have to think that through. But it may be just a byproduct, as you said.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right, okay. Is everyone comfortable with that?

**Peter DeVault – Epic Systems – Project Manager**

Yes.

**M**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Great. Excellent. Can we move forward in the slides, please? Forward a longitudinal care plan. As you can see, the proposed stage two is record a longitudinal care plan for 20% of patients with high priority health conditions, and then the measure increases basically in stage three to longitudinal care plan available for electronic exchange for 50% of patients with high priority health conditions. Let me again just go back to see these notes, so we have that as background. I'll just read it. "I think this metric is fraught with important details that could, if chosen poorly, make the intended tool useless to patients and providers. This is the stuff of regular care summary notes and progress office notes. I think that by mandating some new sort of document, that this muddles in the practice of medicine in yet another way with dubious benefit, how useful is it really if the care plan says: 1. Hypertension. Manage with medication, diet, exercise. 2. Obesity. Diet and exercise advised, etc. This is the stuff of busy work, little or no value but more work." The spirit of his comment is the same thing that we were discussing in the last one, which is the goal of this isn't really going to be a byproduct of the ... care processes that happen in a practice today.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I agree with the sentiment in this case as well.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I couldn't agree more. This is almost beginning to look like we're prescribing how to practice medicine by virtue of using EHRs, expecting that providers are going to now have to produce a longitudinal care plan for every patient. And it doesn't reflect necessarily the way medicine is practiced in many respects and, like Steve said, it adds more to the processing of the information than real value to the patient.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I was at the Markle Connecting for Health meeting yesterday, and Christine was presenting this, and in that discussion as well I think some of these same concerns about overreaching through MU were raised and really debated and discussed. I know there's been some strong support for this, because obviously from a patient perspective you'd like there to be a single document, but just feeling like we're not there yet and we still have a lot of thinking to do about how to support that through a care process.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. Claudia, just one phrase that you just said, if the goal here is that this ought to be something that is something that a patient can understand, then maybe the way to think about this is related a little bit to the conversation we just had about what ought to be provided to ... EHR. That it's basically saying that's

what we're talking about. We want the patient to be able to have a longitudinal care plan that may or may not be a byproduct of those clinical processes, which are thought of as something that are useful to clinicians but they may not be useful to a patient, or understandable by a patient.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I think what's become hard, though, is to produce that you need an adjudication process that we don't have. You'd need for the two docs to talk to each other about like if there's a conflict between recommendations, I mean, one could just be a simple listing of all the things you've been told, and maybe that's useful, but I don't know who is responsible for integrating that.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right.

**Seth Foldy – Wisconsin – State Health Officer**

That would likely be if the patient's in a medical home.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Yes.

**Seth Foldy – Wisconsin – State Health Officer**

That would probably be the primary provider. But I agree with you, it is a bit difficult about adjudication. When you come back from a cancer treatment with an oncologist and they want to provide a care plan for the next year of surveillance, that's the plan that the oncologist is providing back to the primary care doc for maybe carrying out the surveillance. So it does require a lot of coordination, and I know, again, this is something Christine feels very strongly about.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Could there be a responsibility, rather than just a care summary, should specialists be required to send care plans back to primary care physicians?

**Seth Foldy – Wisconsin – State Health Officer**

That was going to be my thought, that one thing technology can enable is to make patients' care plans by different providers visible to one another. So either a mandate to send care plans when produced, or of course from an information exchange perspective the concept of a repository for care plans where one could find out who's planning what for my patient. But those are the two different enablers of this concept without trying to do the impossible.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

So what that suggests, ... the best way I can think of to do that would be to basically make that a content requirement on the summary of care exchange requirement that's already there. So we're saying that for transitions of care a HITSP CCD document has to be shared with certain content, or are we just suggesting or coming to something that says that oh, a care plan ought to be included in that as well, along with the problem ...?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

If it exists.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

That's part of it. That's part of the day to day right now in the standard development ... world, you know, defining what a care plan is and then what is the electronic standard to document that plan. And there's a lot of debate going on, so adding the word "longitudinal" to the whole concept adds even more questions about what truly is a "longitudinal" care plan and then having the requirements to record it, I guess. I like what Seth was pointing to, which is more of the making available electronically of care plans, I don't know if they're longitudinal necessarily. Longitudinal care plans would potentially apply to more the primary care provider that is seeing a particular patient and is coordinating the care of a patient with a chronic condition, a high priority health condition that is a chronic condition. I think this will need to be reframed

into more of having a care plan for patients available to be seen by others, or to be requested or accessed by others would be more appropriate.

The other thing, of course, is that this immediately will point to someone will have to define deregulation, what a care plan is, because that's what everybody's going to be looking for, is what do we mean by a care plan. So now we will have a regulatory body, CMS, regulating the definition of a care plan for the country, which has its own implications of course.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

You don't like that? I wonder if it would be useful in our letter to include some framing about our interest in using meaningful use to drive forward coordinated seamless care, but not overreaching to establish new processes of care or new requirements of care that don't exist. Something that speaks to this set of issues, because I think it cuts across several of the recommendations.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right. Yes, I think that's a good thought. Maybe we can even put in that these are, like this one and the previous one are important concepts that we believe at first pass we could do a little bit of an exercise once we start to converge on a set of stage two recommendations to convince ourselves that they are byproducts in certain ways of the clinical processes that are being defined. And to put the placeholder that as we move forward that they ought to be explicit goals of those care processes. But the characterization really needs to be as byproducts of the care processes and not as specific deliverables on their own. I think that was saying the same thing that you said. Is that right, Claudia?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay. Are we in agreement that we basically want to treat this one like the previous one, to say that as a specific requirement it's a bit of an overreach, but we certainly strongly endorse the spirit and the goal of it, we just think that it ought to be accomplished through different means, and again that Art will tell Christine?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

At your service.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay, are we comfortable with that? It sounds as if I'm not hearing any objections.

**M**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay, great. Can we move to the next slide, please? I just want to do a quick time check here. I'm looking at my off line one, we have just two more. Is that right, Kory, we have this one and the discharge one?

**Kory Mertz – NCSL – Policy Associate**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

And we have about 20 minutes.

**Kory Mertz – NCSL – Policy Associate**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

This one is history, patients can view and download information, so the proposed stage two is 80% of patients offered the ability to view and download via a Web-based portal within 36 hours of discharge relevant information contained in the record about EH inpatient encounters. So this is a hospital requirement. Data are available in human readable and structured forms that the Standards Committee will define. It looks like the stage three, I'm reading through, is the same. So it wouldn't change from stage two to stage three, if I'm not mistaken.

And you can see the comment there, let me quickly bring our virtual Steve into the conversation, and Steve's comment on this is: "We should stick to business days not hours as the time frames. Real clinical care demands that doctors and surgeons act when patients need care, and things like paperwork, computer work, while important, take a back seat to the need to provide real time clinical care. A surgeon who works all day, has to do two emergency surgeries at night, and then has to work the following day quite reasonably won't comply with a 36-hour rule for this stuff. Tasks get lumped and occur unevenly, mandating short turnaround times for clerical work and will result in consequences that are not good for patients and that infuriate clinicians. Five business days should be sufficient for this particularly since we already manage transition summaries in a separate metric."

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

My comment to this one is really kind of in the same line as some of the other points. I think we're beginning to see some reaching beyond the EHR. Remember, this is about meaningful use of EHRs, and we're asking hospitals to create a Web portal, not in the EHR system, but a Web portal to allow patients to see their data, of course the data coming from the EHR, yes, so absolutely. Of course we are in fact doing a lot of this already in Kaiser, and many organizations are doing something like this already. The first question is really is this a requirement about EHRs or a requirement about creating Web portals? Or is a Web portal in EHR functionality expected in the future? If we're going to expect healthcare organizations to make this available via Web portals, is that a certifiable component of an EHR and there are going to be standards for that? My first comment is about that, is whether this is truly part of an EHR program or is now beginning to expand into some requirements that go beyond the EHR?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

So just as a clarification, Walter, if this said something like "80% of patients offered the ability to receive and download their inpatient information according to a set of standards," would you be okay with that?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Absolutely. Exactly. The fact that it's being done via a Web portal is a very defined application that in my mind should not be the only way to do it and is not really part of an EHR program. Of course I do want to be very clear that I'm fully supportive of this ability of patients to access the data, and I agree with Steve that the timing about 36 hours, it should be counted in days rather than hours. So I do fully agree conceptually with the direction in which this is going. I'm very concerned about the fact that this is establishing and requiring to create a Web portal just because this is part of the meaningful use program of EHR functionality.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

So it sounds like we have two friendly amendments; one from Steve, which would expand this to five days, and one from Walter that would just step back a little bit from the particular technology that is used, but just to say that 80% of patients are offered the ability to access that information through a set of standards. That would set up the ability for the Standards Committee to just say and that ought to be lined up with the standards that we're using for everything else.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I thoroughly agree with Walter. I have a little question about this issue that Steve is pointing out. What I see in that comment field off to the right is essentially what's on a sheet that is now given to patients on leaving the hospital. It's not the full dictated summary that a physician completes, as Steve says, when convenient because of all the competing demands. But there are sheets given to a patient when they get discharged that say why they were admitted, what happened, what are the medications, and what are the discharge instructions. So I'm not sure, and I'm a little confused because there are so many different

terms being used around summaries, visit summaries, and I don't really know the terms, but it seems to me that this is very similar to the sheet that's given, I think, according to JCAHO regulations.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

So that's why I would push back a little bit on Steve about the five days for this particular set of data.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Going back to that point, right now there's a requirement to provide discharge instructions, not the ability to download relevant information from obtaining the EHR. Right now, there's a requirement to provide patients with discharge instructions at discharge, so meaning as the patient's walking out of the hospital. I want to just make the distinction that this is not about that. Discharge instructions of course are something that patients need as they're leaving a hospital or a clinic. Accessing relevant information containing the record about a patient within 36 hours of discharge, I don't know, I mean, the workflow process for updating a Web site, or not updating a Web site. But I guess making the data available from the EHR into this, interfacing the EHR appropriately and all those things, and doing whatever work needs to be done within 36 hours is probably not realistic.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I see this, it says, "Discharge summary when available." So what data on this list here would not be available other than the discharge summary?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Where does it say "Discharge summary when available?"

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

About the fifth line from the bottom, Walter. I think if this group were to say we have comments about some of the elements, we should point them out, but it seems to me many of these items are already the ones that are on that sheet when you leave, and this should be generated out of the EHR.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I don't read the "where available." I'm reading, "Proposed stage two: 80% of patients offered the ability to view and download within 36 hours relevant information containing the record about EH inpatient encounters."

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right. Walter, I'm referring to the column all the way on the right.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Oh, the comment.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes. This is embedding here discharge instructions with a whole host of other things. One thing again is discharge instructions, which are instructions that providers give to the patients. Another thing is the whole summary of what happened during the hospitalization. Those are two different sets of data. I don't think they should be mixed together because by mixing them when the 36 hours is ... and of course discharge instructions should be given within minutes, I guess, or immediately as the patient's leaving. All the other information about the encounter can be made available, but like I said, it's not realistic to

expect that in 36 hours all the other un-discharge instructions with data information will be able to be made available. One recommendation would be to separate discharge instructions from all the other elements, because again there are two different timing needs. Art, I don't know if you agree with that or see the same distinction in terms of the timing of discharge instructions?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I think we can separate them out. I think that would be a good goal for this group. But I think a lot of these things should be in the EHR ready for deposit in the CCD. How hard is it to get the smoking status, the advanced directives? All that should be already in the chart; and what's there is produced in an electronic format of 36 hours. I don't know that anybody's saying you may have none of those empty.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Good point. Really there are some data elements here of course that are already part of the record even before the patient came to the hospital or as the patient came into the hospital, of course. That demographic and other information is there. The discharge instructions are more immediate. And then the issue is really the summary of what happened in the hospital to the patient.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I agree with you. That is problematic, and I agree with Steve on that. That's problematic. And I think the out here is "when available" so if Steve says five days I think we can write that back and say that's a reasonable amount of time to get this done. But the other elements seem to be readily available to me.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I think we're here coming down to three groups of data elements in this categorization in the Comments column. One is the demographic and general information about the hospitalization, including discharge dates and locations, anyway, the demographics and that kind of background about the patient. The second group is the discharge instructions. The third group is the discharge summary. By separating the three I think we get a different timing sequence, more easily workable.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Agreed.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

So there's some way of constraining this that we think would be important, and maybe we can figure out off line how to do that. I don't know if it makes sense to try to constrain it for alignment with JCAHO, but we probably don't want to pin something so specifically to something like that. But it sounds like that would certainly be in the spirit of this as well. JCAHO's requiring a whole bunch of these things as standardized, and to Art's point, it's not unreasonable to ask someone in 36 hours that it be delivered to a patient, or made accessible to a patient.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, I don't disagree with that, Micky. I'm just suggesting that by categorizing the types of information it helps clarify the timing of when that information is easily available.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right, okay. So maybe I can ask if you wouldn't mind to take a shot at what those categories are, if you have a good sense of that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, I'd be happy to do that.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay, great. We can put that into the draft of the letter and that will give us all a chance to step back and see if that captures it appropriately.

So just looking at the clock, if we could move to the next one, and this is really one that, per Kory's point earlier, this is the one that isn't a new requirement. This is really an existing stage one requirement on hospitals to provide electronic copies of discharge instructions at discharge for 50% of the time, and it really just raises it to 80% and then to 90% in stage three. I'm not sure that I fully understand what "provide electronic copy of discharge instructions," how that is different than electronic discharge instructions, or is there a difference there? Perhaps someone can weigh in on that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I think it's the same. The word "copy" was just added. I don't know. It's the same. It's just providing ... discharge instructions.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Steve Stack did not have any comment on this, so it sounds like he's okay with it.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes. One comment I think is going to be important is something that is actually noted in the preamble of the final meaningful use rules that clarify the meaning of this. There are many ways of doing this, like it says there. You can give it if the patient elects to receive it, a printed copy, a piece of paper. They can receive it electronically, which means they can be given. Literally this is procedurally what many of us are thinking how we're going to do this, are we going to give people a CD or a DVD or whatever of the knowledge that we have, which implies we have to create the workflows and train people to burn a DVD kind of thing. So that's one-step. Or can we give USBs? USBs don't seem to be necessarily a good way in some instances. Or there's another way, which is sending the patient an e-mail. There's another way yet, which is giving the patient the direction of a Web site where they can access the discharge instructions, linking it back to the previous one, which is why I thought it was important to distinguish those categories of data.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

That is actually one of the ways many of us are looking at it is really giving the patient, well, you can get it by paper, we can give you a CD, we can send you an e-mail, or we can give you a Web site where you can actually go and see it and download those instructions. I think those should be mentioned here.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Oh, okay. I guess I was just going to suggest that given that there are multiple paths to doing this and there are probably many institutions that are in the same situation as Kaiser, that you're really thinking hard about how to do this. The only thing that I think is being asked here is, is the trajectory of 50%, 80%, 90% reasonable?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, I don't have issues with the trajectory. I think what I have issues with is the definition of electronic discharge instructions, not the ... but the ....

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

If you add a little bit of language on that we can certainly consider it I think off line with the working group as a part of the letter building process.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

There is no standard for this yet?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

No, not that I'm aware of.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

To be—

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

When you say “standard,” Art, do you mean like—

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

A clinical care document or something that would contain this.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

No. The idea is that this would be human readable, so what you would print on a piece of paper is what you will burn as a PDF on a DVD. You wouldn't give a patient a CDA necessarily, or something like that. This is discharge instructions only.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

This is just an electronic version of that paper form. It's not trying to communicate it to another system?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Right.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

This is to give to the patient.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Yes. Walter, I think you're right. There is a lot of ambiguity around the language. As I recall, there was something strange in there that said “per patient preference” and it said “electronic” but it does say that the patient can choose paper, which was bizarre. It tells the hospital it has to be electronic, but it has to be per patient preference and if the patient says they want paper you have to give it to them as paper.

So if we're okay with the trajectory here, and I'm not hearing any objection for all that's being asked for, and, Walter, you had some further thoughts on clarifying the language, I think we can certainly entertain that as a workgroup as a part of the process of building the letter, if you have something to offer there. Is everyone okay with that as a path?

**M**

Sure.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay, that's the last one, actually. We have a call on April 15<sup>th</sup>, where we'll take up the public health and the broader HIE questions. Let me turn it over to Judy for public comment.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Operator, can you please check with the public to see if anybody wishes to make a comment?

**Operator**

We have no public comments at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. Thank you, Micky, and thank you, everybody.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO**

Okay. That's great. Thank you.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Bye.

## **Public Comment Received During the Meeting**

1. There is a behavioral message that could be worth preserving in pHR information arising from eHR data in that, if a person (patient) wants full disclosure of their generated information, it should be available.

2. I think the real question is the "relevant" qualifier...it seems the answer could simply "available information", presumably required by MU. Their presumed ability to understand may not be an issue. Further, the speed of turnaround may resemble a satisfaction issue within an expanded "standard of care."